

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555456	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Antelope Valley Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 44567 North 15th St. West Lancaster, CA 93534	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled residents (Resident 2) was free from physical abuse (deliberately aggressive or violent behavior with the intention to cause harm by one person towards another) when on 7/8/2026, at 8:30 a.m., while Resident 1 was seated in a wheelchair, Resident 1 used his (Resident 1) left palm and struck Resident 2's forehead while Resident 2 was also seated in a wheelchair in the hallway. As a result, on 7/8/2026, at 8:30 a.m., Resident 2 was subjected to physical abuse while under the care of the facility. Resident 2 sustained a reddened forehead with a bump (any raised area or swelling) measuring approximately one inch long and one inch wide and Resident 2 had facial grimace, yelled and had guarding behavior of covering her (Resident 2) forehead due to pain (pain level not specified). On 7/8/2026, at 8:55 a.m., Resident 2 was transferred and presented with a head injury and forehead hematoma (a closed wound where blood collects and fills a space inside your body) at General Acute Care Hospital 1 (GACH 1) for further evaluation and treatment. Findings: During a review of Resident 1's undated admission Record, the admission Record indicated the facility admitted Resident 1 on 3/27/2019, with diagnoses that included metabolic encephalopathy (a brain dysfunction caused by an underlying condition), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities), and difficulty in walking. During a review of Resident 1's Change in Condition (CIC - a document used to record and report any significant changes in a resident's status), dated 4/26/2026, the CIC indicated Resident 1 had behavioral symptoms (outward, observable actions that deviate from typical norms and disrupt daily functioning) and physically punched staff's (admission Clerk [AC]) jaw. The CIC indicated the facility transferred Resident 1 to GACH 2 for psychiatric evaluation (a structured assessment process used to diagnose mental health conditions and create effective treatment plans). During a review of Resident 1's CIC, dated 5/6/2026, the CIC indicated Resident 1 had behavioral symptoms of aggression (any physical or verbal behavior intentionally aimed at causing harm, pain, or destruction to another person) towards staff (Licensed Vocational Nurse 5 [LVN 5]) with increased confusion. The CIC indicated the Physician ordered to transfer Resident 1 to GACH 2. During a review of Resident 1's History and Physical (H&P - a medical examination that involves a doctor taking a resident's medical history, performing a physical exam, and documenting their findings), dated 5/11/2026, the H&P indicated Resident 1 had agitation (a feeling of irritability, mental distress or severe restlessness), behavioral changes and was transferred to the GACH (not specified) for evaluation. During a review of Resident 1's CIC, dated 5/20/2026, the CIC indicated Resident 1 had physical aggression towards staff during activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The CIC indicated Resident 1 struck Certified Nursing Assistance (CNA) 2's face during ADLs. The CIC indicated the physician was (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	notified with orders for a consult with a psychiatrist (a licensed medical doctor who specializes in mental health), urinalysis (UA - urine test), complete blood count (CBC - a routine blood test that measures the number and types of cells in your blood), and complete metabolic panel (CMP - a standard blood test that measures 14 different substances to give your doctor a snapshot of your overall health).During a review of Resident 1's Progress Notes, dated 5/20/2026, timed at 9:45 a.m., the Progress Notes indicated on 5/20/2026, at 9:40 a.m., Resident 1 was seated in the wheelchair in the hallway and CNA 2 was checking Resident 1's blood pressure (the force of the blood pushing against the walls of the arteries as the heart pumps it through the body) when Resident 1 struck CNA 2's face.During a review of Resident 1's Order Summary Report, dated 5/20/2026, the Order Summary Report indicated a physician's order to monitor Resident 1 for behavior of striking out staff during ADLs every shift.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 6/2/2026, the MDS indicated Resident 1 had severely impaired cognitive skills (resident had lost the ability to think, learn, remember, or make decisions to the point that resident cannot live independently and require full-time supervision or help with daily tasks like eating and dressing) for daily decisions. The MDS indicated Resident 1 needed maximum assistance from staff for dressing and personal hygiene. The MDS indicated Resident 1 used a walker (a mobility [the ability to move freely and easily] aid that helps provide stability and balance while a resident walks) and a wheelchair.During a review of Resident 1's Medication Administration Record (MAR - flowsheet that indicates medications given to a resident), dated 7/2026 (whole month of July 2026), the MAR indicated Resident 1 had four episodes of striking staff on 7/3/2026.During a review of Resident 1's CIC, dated 7/8/2026, at 8:30 a.m., the CIC indicated Resident 1 had an episode of physical aggression on 7/8/2026. The CIC indicated a staff (Physical Therapy Assistant [PTA]) observed Resident 1 engaged in a physical altercation (a dispute between individuals in which one or more people sustain a bodily injury). The CIC indicated Resident 1 used the palm of his (Resident 1) hand and struck Resident 2 on the left side of the head. The CIC indicated the Physician was notified on 7/8/2026 at 8:43 a.m. and ordered haloperidol (medication used to treat nervous, emotional, and mental conditions) injection (the act of putting a medicine into the body using a syringe [a simple pump to inject or withdraw liquids] and a needle) five milligram per milliliter (Mg/ML - a unit of measurement), Ativan (medication used for short-term relief of severe anxiety and or panic attacks) injection two (2) mg/ml, and an order to notify the psychiatrist immediately for Resident 1.During a review of Resident 1's Progress Notes, dated 7/8/2026, timed at 8:42 a.m., the Progress Notes indicated Resident 1 had uncontrollable hitting and striking of staff on 7/8/2026. The Progress Notes indicated Quality Assurance Nurse (QAN) 1 called the Physician with an order for Ativan 1 milligram (mg - metric unit of measurement, used for medication dosage and/or amount) and Haldol 1 mg intramuscular (IM - inside the muscle) injection (the act of using a needle and syringe to force liquid medicine, fluids, or vaccines directly into a person's body) stat due to agitation and psychiatrist to arrange for Resident 1 to go to GACH (not specified) for behavioral evaluation (a systematic method used to observe, measure, and understand how an individual acts in specific situations).During a review of Resident 1's Progress Notes, dated 7/8/2026, timed at 7:10 p.m., the Progress Notes indicated an ambulance picked up Resident 1 at 7:10 p.m. (on 7/8/2026), and transferred to GACH 3 for behavioral evaluation.During a review of Resident 2's undated admission Record, the admission Record indicated the facility admitted Resident 2 on 1/3/2026, with diagnoses that included other sequelae of cerebral infarction (the residual, long-term symptoms or complications that persist after a patient has suffered a stroke [brain attack]), unspecified dementia and generalized muscle weakness.During a review of Resident 2's History of Present Illness (HPI), dated 1/4/2026, the HPI indicated Resident 2 had the (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	capacity to make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 2 used a walker and a wheelchair. During a review of Resident 2's CIC, dated 7/8/2026, the CIC indicated Resident 2 had a .raised bump. on his head. The CIC indicated the Physician was notified and ordered to transfer Resident 2 to GACH 1 for computed tomography (CT - a diagnostic imaging test that combines X-rays [medical imaging that uses radiation to take pictures of the inside of your body] with computer processing to create detailed pictures of the inside of your body) scan of the head. The CIC indicated Resident 2 had a raised area on the front of the head with increasing pain when bump was touched. During a review of Resident 2's Pain Observation/Assessment, dated 7/8/2026, the Pain Observation/Assessment indicated Resident 2 had nonverbal (not involving or using spoken or written words) signs of discomfort with sharp pain to the head as evidenced by wincing (an involuntary, slight grimace or flinch) and yelling out when the raised area in the forehead was touched. During a review of Resident 2's Comprehensive Skin Evaluation/Assessment, dated 7/8/2026, the Comprehensive Skin Evaluation/Assessment indicated a raised area measuring approximately one inch in length and one inch wide noted on the frontal area (refers to the front section of the skull [the bony frame of the head] and scalp [the skin and hair that covers the top and back of the head]) of Resident 2's head. During a review of Resident 2's Progress Notes, dated 7/8/2026, timed at 8:30 a.m., the Progress Notes indicated, on 7/8/2026, Resident 2 was in the hallway near Resident 1 when Resident 1 struck Resident 2. The Progress Notes indicated Registered Nurse (RN) 1 assessed Resident 2 who had a raised area in the forehead and displayed nonverbal signs of discomfort including wincing and yelling out when forehead was touched. During a review of Resident 2's Progress Notes, dated 7/8/2026, the Progress Notes indicated that on 7/8/2026 at 8:45 a.m., Emergency Medical Services (EMS - the system of professionals provide pre-hospital medical care and transport in emergencies) and Fire Station A (FSA) arrived at the facility and transferred Resident 2 to GACH 1 at 8:55 a.m. (on 7/8/2026) for further evaluation and treatment. During a review of Resident 2's GACH 1 Emergency Documentation, dated 7/8/2026, the Emergency Documentation indicated on 7/8/2026, at 9:31 a.m., Resident 2 presented with a head injury and forehead hematoma. During a review of Resident 2's GACH 1 CT brain/head, dated 7/8/2026, timed at 11:15 am., the CT scan indicated Resident 2 had mild left forehead scalp soft tissue swelling (a buildup of fluid, blood, or inflammation in the layers of skin and tissue on the outside of the skull). During a review of Resident 2's Progress Notes, dated 7/8/2026, timed at 3:22 p.m., the Progress Notes indicated Resident 2 returned to the facility. During an interview on 7/9/2026, at 8:46 a.m., with the Director of Staff Development (DSD), the DSD stated on 7/8/2026, at 8:30 a.m., she (DSD) was inside her (DSD) office when the PTA passed by her (DSD) office and reported that Resident 1 hit Resident 2. The DSD stated she (DSD) walked out of her (DSD) office and followed the PTA and noticed Resident 2 seated on a wheelchair outside of Room A, holding her (Resident 2) forehead. The DSD stated the PTA went with Resident 1 and she (DSD) stayed with Resident 2. The DSD stated Resident 2 was upset while holding her (Resident 2) forehead and Resident 2 verbalized that Resident 1 hit her (Resident 2). The DSD moved Resident 2's hand from her (Resident 2) forehead and noticed a bump. During an interview on 7/9/2026, at 8:53 a.m., with the PTA, the PTA stated on 7/8/2026, at 8:30 a.m. she (PTA) was walking towards the gym when she (PTA) passed by the hallway and noticed something from the corner of her (PTA) eye. The PTA stated when she (PTA) turned her (PTA) head, she (PTA) witnessed Resident 1 who was seated in a wheelchair swung his (Resident 1) left arm and with an open hand Resident 1's left palm hit Resident 2's left forehead. The PTA stated she (PTA) also heard a thud sound (a dull, heavy sound made when a solid, heavy object hits another surface) (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	when Resident 1's left palm hit Resident 2's left forehead. The PTA stated she (PTA) saw Resident 2 grimaced and grabbed her (Resident 2) forehead right away. The PTA stated she (PTA) reported to the DSD that Resident 1 and Resident 2 were fighting and she (PTA) separated Resident 1 away from Resident 2. The PTA stated physical abuse is when someone hurts somebody physically. The PTA stated the incident between Residents 1 and 2 was abuse. During an observation and interview on 7/9/2026, at 9:24 a.m., at Resident 2's bedside, Resident 2 laying on bed with a forehead bump and fading bruise. Resident 2 stated her (Resident 2) forehead still hurts when touched. Resident 2 stated she (Resident 2) cannot remember how she (Resident 2) got hurt. During an interview on 7/9/2026, at 9:30 a.m., with Registered Nurse (RN) 1, RN 1 stated on 7/8/2026, at 8:30 a.m., she (RN 1) was in Nursing Station B when the incident happened in the hallway of Nursing Station A. RN 1 stated Quality Assurance Nurse (QAN) 1 reported to her (RN 1) that Resident 1 struck Resident 2 in the face. RN 1 stated she (RN 1) noticed Resident 1 getting combative (the tendency to be argumentative, hostile, or physically aggressive) and swinging his (Resident 1) arms at everyone. RN 1 stated she (RN 1) took care of Resident 1 first and went to Resident 2 and noticed the bump on her (Resident 2) forehead. RN 1 stated Resident 2 made pain-related noise (unspecified). RN 1 stated Resident 2 did not verbalize her (Resident 2) pain level. RN 1 stated a cold pack (or ice pack) was applied, and Resident 2 refused pain medication. RN 1 stated physical abuse is when someone physically hits another person. RN 1 stated based on the definition of abuse, Resident 1 abused Resident 2. During an interview on 7/9/2026, at 9:56 a.m., with the DSD, the DSD stated Resident 1 abused Resident 2. The DSD stated that because Resident 1 hit Resident 2, Resident 2 had a forehead injury and was transferred to GACH 1. During an interview on 7/9/2026, at 9:59 a.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she (LVN 1) was regularly assigned to Resident 2. LVN 1 stated on 7/8/2026, at 8:30 a.m., she (LVN 1) administered medication (not specified) to Resident 2's roommate (not specified) inside Resident 2's room. LVN 1 stated Resident 2 was outside the room in the hallway seated in a wheelchair. LVN 1 stated after medication administration she (LVN 1) went out of Resident 2's room and noticed Resident 2 in Nurses Station A with an icepack on her (Resident 2) forehead. LVN 1 stated Resident 2 cannot verbally report the pain level but appeared in pain due to facial expression of grimace and yelling and her (Resident 2) body language of guarding her (Resident 2) forehead. LVN 1 stated the incident was a resident-to-resident abuse and Resident 2 got hurt in the situation. During an interview on 7/9/2026, at 10:06 a.m., with Quality Assurance Nurse 1 (QAN 1), QAN 1 stated on 7/8/2026, just after 8:30 a.m. the DSD informed her (QAN 1) of the incident. QAN 1 stated the DSD took Resident 2 in Nursing Station A and she (QAN 1) stayed with Resident 1 until the Unit Coordinator (UC) came and wheeled Resident 1 to Nursing Station C. QAN 1 stated Resident 1 was still agitated and still tried to hit her (QAN 1) and the UC for two minutes. QAN 1 stated she (QAN 1) notified the Physician, and the Physician ordered Ativan and Haldol IM. QAN 1 stated Resident 1 calmed down after a while until he (Resident 1) was picked up through 5150 (an involuntary 72-hour psychiatric hold allowing designated medical professionals or police to legally hold a person in a hospital for up to three days if they are deemed a danger to themselves or others or are unable to care for their basic needs) the night of 7/8/2026. QAN 1 stated Resident 1 had agitation in the past. QAN 1 stated the incident between Resident 1 and Resident 2 was abuse. During an interview on 7/9/2026, at 10:14 a.m., with the Assistant Director of Nursing (ADON) 1, the ADON 1 stated the incident between Resident 1 and Resident 2 was an abuse incident. ADON 1 stated Resident 2 had swollen and reddened forehead. During an interview on 7/9/2026, at 10:18 a.m., with the Administrator (ADM), the ADM stated he (ADM) was the Abuse Coordinator and the facility's policy was that all residents have the right to be free from abuse. The ADM stated Resident 1 abused Resident 2 because Resident 1 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	struck Resident 2.During a concurrent interview and record review on 7/9/2026, at 11:01 a.m., with QAN 2, Resident 1's CICs, dated 4/26/2026, 5/6/2026, and 5/20/2026 were reviewed. QAN 2 stated the CIC, dated 4/26/2026, indicated Resident 1 had behavioral signs and punched AC's jaw. QAN 2 stated the CIC, dated 5/6/2026, indicated Resident 1 had behavioral signs of increased confusion and aggression towards staff and Resident 1 struck LVN 5's face. QAN 2 stated the CIC, dated 5/20/2026, indicated Resident 1 had physical aggression while seated in the hallway and struck CNA 2's face during ADLs. QAN 2 stated Resident 1 had three episodes of striking a staff.During a review of facility's policy and procedure (P&P), titled, Abuse, Neglect, Exploitation (taking unfair advantage of someone or something for personal gain or profit) and Misappropriation (using someone else's money, property, or ideas for a purpose the owner never intended) Prevention Program, dated 5/2024, and last reviewed on 5/20/2026, the P&P indicated, Residents have the right to be free from abuse, neglect. This includes but is not limited to . physical abuse. 1. Protect residents from abuse . but not necessarily limited to: . b. other resident.During a review of facility's P&P, titled, Identifying Types of Abuse, dated 5/2024, and last reviewed on 5/20/2026, the P&P indicated, Abuse of any kind against a resident is strictly prohibited. Physical Abuse: 1. Physical abuse includes, but is not limited to hitting, slapping, biting, punching or kicking.During a review of facility's P&P, titled, Recognizing Signs and Symptoms of Abuse/Neglect, dated 5/2024, and last reviewed on 5/20/2026, the P&P indicated, All types of resident abuse . are strictly prohibited. 4. The following are signs and symptoms of abuse/neglect that should be promptly reported. This listing is not all-inclusive. Other signs and symptoms or actual abuse/neglect may be apparent. a. Signs of physical abuse: . (5) Bruises, including those found in unusual locations such as the head, neck, lateral locations on the arms or posterior trunk and torso, . and/or (6) Facial injuries, including broken or missing teeth, facial fractures (break in a bone), black eyes, bruising, or swelling, or bleeding of the mouth and cheeks.		